Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 B. WING _ HAL026017 10/29/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 FORSYTHE STREET CAROLINA INN AT VILLAGE GREEN FAYETTEVILLE, NC 28303** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 000 Initial Comments C 000 This is a Report of a Biennial Construction Survey conducted by Greg Cates and Billy Bryant on October 29, 2015. Based on information gathered from our files, the Facility was first licensed on December 5, 1996 for One Hundred (100) residents. Based on this information, we are requiring the facility to meet the 1996 Rules for the Licensing of Domiciliary Homes and the 1996 North Carolina State Building Code, Section 419- Institutional Occupancy; and the applicable portions of the 2005 Rules for Adult care Home of Seven or More Beds. C 144 C 144 Med Prep Area-Sink with Lever Handles SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL **ENVIRONMENT** (f) The requirements for storage rooms and closets are: (5) Handwashing facilities with wrist type lever handles shall be provided immediately adjacent to the drug storage area; This Rule is not met as evidenced by: 1- Based on observations, the facility has failed to provide lever handles at the faucet in the Med Rooms. This deficiency may affect all residents who are dispensed medicine from the Med Room by possibly allowing cross contamination. Findings include: a- The sink in the Med Room on the Terrace Level is equipped with knobs for turning on the water.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: 01		COWIFLETED		
		HAL026017	B. WING		10/2	9/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAROLI	NA INN AT VILLAGE O	REFN	SYTHE STRE VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 164	Continued From pa	ge 1	C 164			
C 164	Housekeeping and	Furnishings-Clean, Repaired	C 164			
	FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of (e) This Rule shall facilities. This Rule is not me 1- Based on observe maintain the buildin Findings included and another than the corridor of the	es shall: ings, and floors or floor n and in good repair; c unpleasant odors; elean and in good repair; apply to new and existing et as evidenced by: rations, the facility has failed to gs in good repair and clean. e: the Freight Elevator Lobby or is missing pieces of trim. carpet outside the Freight				
C 166	Housekeeping-Mair	ntained Free of Hazards	C 166			
		06 HOUSEKEEPING AND				

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hazards;

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
HAL026017		B. WING		10/29/2015		
	PROVIDER OR SUPPLIER	400 FORS	DRESS, CITY, S	STATE, ZIP CODE E ET		
CAROLII	NA INN AT VILLAGE G	FAYETTE'	VILLE, NC 2	28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 166	Continued From pa	ge 2	C 166			
	(e) This Rule shall facilities.	apply to new and existing				
	maintain the buildin storing oxygen cont them from falling ox could affect all pers	et as evidenced by: vations, the facility has failed to g free of hazards by not tainers securely to prevent ever or rolling around. This tons in the facility as the could fall over, damaging the				
	Findings include:					
	a- There are oxygen bottles being stored in unapproved containers in Resident Room 212. b- There are oxygen bottles being stored in unapproved containers in the 2nd Floor Storage Room. c- There are oxygen bottles being stored in unapproved containers in the 1st Floor Med Room.					
C 189	Building Equipment	Maintained Safe, Operating	C 189			
	mechanical, and plu care home shall be operating condition (k) This Rule shall facilities with the ex	11 OTHER d all fire safety, electrical, umbing equipment in an adult maintained in a safe and				
	This Rule is not me	et as evidenced by:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
HAL026017		B. WING		10/29/2015		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
CAROLII	NA INN AT VILLAGE (GREEN	SYTHE STRE VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 189	Continued From page 3		C 189			
	1- Based on observations, the facility failed to ensure that the building is safe by not maintaining the emergency EXITS. This deficiency directly affects all residents, personnel, and visitors by possibly preventing people from exiting the building in an emergency.					
	Findings on include: a- The EXIT doors from the 1st Floor Dining Room are difficult to open and					
	requires special knowledge by requiring the handle to be pushed up to unlock the doors prior to opening.					
	2- Based on observations, the facility failed to ensure that the building is safe by not maintaining the fire resistance of building components. This deficiency directly affects all residents, personnel, and visitors by allowing the possible spread of smoke beyond the compartment of origin.					
	Findings includ	e:				
	a- The corridor door to the 3rd Floor Freight Elevator Lobby on the rubs against the frame and does not close completely and latch.					
	maintain the buildir operating. This def persons who have	vations, the facility has failed to ag electrical system safe and iciency may affect those access to the electrical room ssible electrocution due to bltage wiring.				
	Findings includ	e:				
	a- There is a circuit blank missing in the electrical panel in the Electrical/ Telephone					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: 01		COMPLETED		
		HAL026017	B. WING		10/29/2015	
NAME OF I	PROVIDER OR SUPPLIER	STRFFT AF	DRESS. CITY S	STATE, ZIP CODE		
		400 FOR:	SYTHE STRE	,		
CAROLII	NA INN AT VILLAGE O	REEN	VILLE, NC 2			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	.D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				·		
C 189	Continued From pa	age 4	C 189			
	Room.					
	4- Based on observ	vations, the facility has failed to				
		ng electrical system safe and				
	operating due to the	e GFCI receptacles not				
		ency may affect staff who				
		itchen and could cause a				
	person to suffer electrocution.					
	Findings includ	e:				
	a- The GFCI re	eceptacle beside the sink in				
		erving Kitchen does not trip				
	when tested.					
	b- The GFCI receptacle beside the sink in					
	the Main Kitchen on the Terrace Level does not trip when tested.					
	does not uip wi	nen testea.				
		vations, the facility has failed to				
		lding is safe by not maintaining				
		of building components. This				
		affect all residents, personnel, wing the possible spread of				
		compartment of origin.				
	omono poyona are	comparation of origin.				
	Findings includ	e:				
	a- Many of the	one-hour rated ceiling tiles				
	in the Sprinkler	Riser Room are damaged				
	or missing.					
	6 Based on observ	vations, the facility has failed to				
		ing systems safe and				
		aintaining an air gap at the ice				
		y allow bacteria to migrate into				
	the ice machine.	•				
	_ The	and a sing for the site of				
		sate pipe for the ice ended into the floor drain.				

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		HAL026017	B. WING		10/2	29/2015
	PROVIDER OR SUPPLIER	REFN 400 FORS	DRESS, CITY, S SYTHE STRE VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 195	Continued From pa	ge 5	C 195			
C 195	Hot Water System		C 195			
	provide an adequat kitchen, bathrooms closets and soil utili temperature at all fi be maintained at a (38 degrees C) and F (46.7 degrees C) (k) This Rule shall facilities with the ex	system shall be of such size to e supply of hot water to the , laundry, housekeeping ty room. The hot water xtures used by residents shall minimum of 100 degrees F shall not exceed 116 degrees				
	the facility has failed temperature between Fahrenheit. This de	rations and testing practices, d to maintain the hot water en 100 and 116 degrees ficiency could affect all be in the facility and use the				
	a- The hot wate Room 301 regis b- The hot wate	er temperature in Resident sters 124 degrees Fahrenheit. er temperature in Resident sters 94 degrees Fahrenheit.				
C 199	Exhaust Ventilation		C 199			
	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (g) The spaces list					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: 01		COMPLETED				
HAL026017		B. WING		10/29/2015				
NAME OF F		CTDEET AS	DDECC CITY (CTATE ZID CODE				
NAIVIE OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
CAROLIN	NA INN AT VILLAGE (SYTHE STRE					
			VILLE, NC 2					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE		
170			IAO	DEFICIENCY)				
C 199	Continued From pa	ige 6	C 199					
	provided with exhai	ust ventilation at the rate of						
	•	ninute per square foot. This						
		not apply to facilities licensed						
		, with natural ventilation in						
	these specified spa							
	(1) soiled linen sto							
	(2) soil utility room:							
	(3) bathrooms and							
	(4) housekeeping closets; and(5) laundry area.(k) This Rule shall apply to new and existing							
	facilities with the exception of Paragraph (e)							
		ly to existing facilities.						
	This Rule is not me	et as evidenced by:						
		rations and testing, the facility						
		ain the mechanical exhaust						
	systems in working	condition. This may affect all						
		ling as it prevents the						
		s and possible bacteria or						
	germs that may cau	use illness.						
	Findings includ	e:						
	a The authorist	for in the bothroom of						
		fan in the bathroom of 1 121 is not working.						
	Resident Room	1 121 IS HOL WORKING.						

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